United Nations A/68/825

General Assembly

Distr.: General
2 April 2014

Original: English

Sixty-eighth session
Agenda item 10
Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declarations on HIV/AIDS

Towards ending the AIDS epidemic: meeting the 2015 targets and planning for the post-2015 era

Report of the Secretary-General

Summary

As the 2015 deadline fast approaches for reaching the targets and commitments set by the General Assembly in its 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (resolution 65/277, annex), evidence shows that the global HIV response has reached an important stage. New HIV infections and AIDS-related deaths continue to decline. Optimism is high that the world will eliminate new HIV infections among children and keep mothers alive. Despite continuing economic challenges and competing priorities, the total resources available for HIV programmes in low- and middle-income countries continue to grow.

The world has an historic opportunity to lay the foundation for ending the AIDS epidemic. However, success is not assured. While recent progress and overall global trends are encouraging, they mask the reality that far too many people living with and affected by HIV are being left behind. In dozens of countries, lifesaving antiretroviral treatment reaches only a fraction of those who are eligible and worldwide, only about one in three people eligible for treatment were receiving it as at December 2012.

Far too often, discrimination, criminalization and punitive approaches are limiting an effective HIV response for those in greatest need, especially key populations at higher risk of infection. Of particular concern is the emergence of new legislative initiatives to criminalize certain key populations, which not only violates human rights but also drives people away from essential services. Experience has demonstrated that fear, blame and ostracism are not the ingredients for success in the HIV response. We have more tools than ever to address the epidemic and our response must be guided by science and shared values rather than by prejudice and denial.

14-28802 (E) 170414

Please recycle

The AIDS response is also failing young people. Children are roughly only half as likely as adults to obtain antiretroviral therapy when needed. Even as AIDS-related deaths decline overall, HIV-related mortality among adolescents has increased by 50 per cent since 2005. In sub-Saharan Africa, infection rates remain substantially higher among girls than among boys of a similar age.

Although we are within reach of several of the key targets and goals for 2015, AIDS will remain an urgent global health and development challenge when the calendar turns to 2016. In order to build on the extraordinary gains that have been achieved and address persistent challenges, ending AIDS will need to be given a prominent place in the post-2015 development agenda. The AIDS response has much to offer the broader development field, with its emphasis on advocacy, community empowerment, high-level political leadership, evidence- and rights-based action, innovative models of care and prevention and broad-based partnerships and collaboration. Similarly, the AIDS response will be immeasurably strengthened if it is taken out of isolation to serve as a mechanism to accelerate progress across the future sustainable development goals. In particular, there are important synergies between the AIDS response and global efforts to eliminate extreme poverty, ensure universal health coverage and reduce inequalities.

Ending the AIDS epidemic will be an historic global achievement for the entire human family, one that will, in the process, also enhance gender equality, promote human rights and address the determinants of inequity and exclusion. While 2015 represents a major milestone in the AIDS response, the work must continue and intensify if we are to achieve the shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

I. Introduction

1. Having strived for more than 30 years to address one of the most serious health challenges of our time, the world is witnessing historic gains in the response to HIV. The number of new HIV infections and AIDS-related deaths globally continues to decline, with especially striking reductions in the number of children newly infected with HIV. Many countries have taken steps to increase domestic public sector financing for HIV-related activities, an encouraging sign for the long-term sustainability of the response.

2. These advances, while impressive, are not seen everywhere, as new HIV infections continue to rise in many countries, especially among key populations. Although tools are available for laying the foundation to end AIDS, they have yet to be fully leveraged. Condom provision is stalling and less than half of the people eligible for antiretroviral therapy under the World Health Organization (WHO) 2013 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* are currently receiving lifesaving treatment services. Owing in large part to the failure to effectively address the underlying social determinants of HIV vulnerability, progress in the response could well be stalled or even reversed in future years, underscoring the urgent importance of continued vigilance, international solidarity and strengthened efforts.

3. In the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex), countries united around the goal of laying a strong foundation to end the epidemic. The 2011 Political Declaration pledges concerted action to achieve a series of milestones by the end of 2015. To support the achievement of those targets, countries committed to close the AIDS resource gap, to promote a response more closely linked with broader development efforts and to eliminate gender inequalities, stigma and discrimination.

4. As the time of writing, barely 600 days remain before the 2015 targets and commitments come due. While the world is presently on track to meet some of the 10 priority targets and commitments of the 2011 Political Declaration, we remain short of achieving most of them. In far too many countries, few, if any, of the targets will be achieved by 2015 if current trends continue. It is essential that countries immediately redouble their efforts to ensure that proven approaches are fully implemented, scaled up and strategically focused on the geographic settings and populations where they will have the greatest impact. At the same time that these responses are being strengthened and accelerated, efforts to lay the groundwork for a sustainable, and effective response beyond 2015 are essential for long-term success. As the progress over the past decade indicates, ending AIDS is within our grasp, and we have an exceptional number of lessons learned on which to build. However, the degree to which we achieve that goal is largely up to us.

II. Global AIDS epidemic: a status report

5. As at December 2012, an estimated 35.3 million (32.2 to 38.8 million) people were living with HIV worldwide. Women comprise 50 per cent of all people living with HIV, including an estimated 58 per cent in sub-Saharan Africa. The epidemic continues to disproportionately affect sub-Saharan Africa, which accounts for an

estimated 71 per cent of all people living with HIV globally, 70 per cent of new HIV infections and 75 per cent of AIDS-related deaths. Outside sub-Saharan Africa, the largest number of people living with HIV is in the Asia-Pacific region (4.8 million people in 2012, of whom 36 per cent are women), although HIV prevalence is substantially lower than in sub-Saharan Africa.

6. Promising epidemiological trends demonstrate that HIV prevention and treatment programmes are having an impact. The estimated number of new HIV infections in 2012 globally (2.3 [1.9-2.7] million) was 33 per cent lower than the number in 2001, while the annual number of AIDS-related deaths (1.6 [1.4-1.9] million in 2012) has fallen by 30 per cent since 2005.

7. However, not all countries, communities and populations are sharing in these gains. New HIV infections continue to increase in Eastern Europe, Central Asia, the Middle East, North Africa and parts of Asia. No notable reduction in the pace of AIDS-related deaths has been reported in the regions where new infections continue to increase.

8. The epidemic varies widely within and between countries and regions. In Kenya, for example, 9 of the country's 47 counties account for 54 per cent of new HIV infections, while 70 per cent of incident infections in Thailand occur in 33 provinces. Although there are limited data on HIV risk among transgender men and women, a desk review of information from 15 countries found that transgender women are 49 times more likely than adults of reproductive age generally to have HIV. HIV prevalence is 13.5 times higher among female sex workers than among women overall. Men who have sex with men are 19 times more likely to be living with HIV than men generally. In at least 49 countries, HIV prevalence among people who inject drugs is at least 22 times higher than among the general population. Globally, the prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis may, in some cases, be up to 50 times higher among prison populations than among the general population.

9. The epidemic continues to exact an enormous toll on the world's young people (ages 15 to 24), who account for 39 per cent of new HIV infections among adults. Risks for young women are especially pronounced. In sub-Saharan Africa, young women aged 15 to 24 are twice as likely to be living with HIV as young men their age. In the midst of broad declines in AIDS-related deaths, the number of adolescents (ages 10 to 19) dying of AIDS-related causes actually increased by 50 per cent between 2005 and 2012 — a clear indication that the response is largely failing to reach many young people.

10. As scaled-up antiretroviral therapy extends lives and improves quality of life, older adults are accounting for an increased share of people living with HIV. Globally, an estimated 3.6 million (3.2 to 3.9 million) people living with HIV were over age 50 in 2012, the first time in the epidemic's history that older adults comprised more than 10 per cent of people living with HIV. This global trend follows earlier patterns seen in high-income countries, where 30 per cent or more of people living with HIV are over age 50. As the overall population living with HIV ages owing to improved treatment options, the programmes serving them will need to address not only HIV but also the health and living challenges associated with ageing.

III. Progress towards the 2015 targets

11. This section describes progress towards the 2015 targets set out in the 2011 Political Declaration. For each of the 10 targets and elimination commitments discussed below, continuing challenges and the key action steps needed to meet those challenges are described. Although the discussion focuses on past achievements and gaps, experience to date has enabled the global community to identify the most promising strategies for overcoming key barriers, providing a strong foundation on which to reach the goal of ending AIDS in the post-2015 era.

1. Reduce sexual transmission of HIV by 50 per cent by 2015

12. Important progress has been made in preventing sexual HIV transmission. The annual number of new HIV infections in sub-Saharan Africa fell by 34 per cent between 2001 and 2012, with a decline of 49 per cent reported in the Caribbean during the same period. In 16 sub-Saharan African countries, adult HIV incidence declined by more than 50 per cent between 2001 and 2012. Reductions in new infections flow in large measure from changes in sexual risk behaviour, including increased condom use, delayed sexual debut and a decrease in the average number of sexual partners. However, recent national household surveys have detected increases in the number of sex partners and reductions in condom use in several African countries, underscoring the need for continued investments in primary HIV prevention to sustain prevention advances.

13. Although continued scale-up of antiretroviral therapy (see paras. 25 to 32 below) is buttressing HIV prevention efforts, the commitment to other forms of HIV prevention may be waning. The number of donor-funded male condoms in low- and middle-income countries dropped from 3.4 billion in 2011 to 2.4 billion in 2012, while the number of donor-provided female condoms fell from 43.4 million to 31.8 million. Midterm reviews in 2013 of national progress towards the 2015 targets reflected declining support in several countries for social and behavioural HIV prevention programmes. Many young people lack access to comprehensive sexuality education that responds to their evolving needs and capacities and remain largely uninvolved in policy dialogues regarding issues that affect them. Continued support for evidence-based prevention is needed to lower the still unacceptably high rate of new HIV infections and to avert possible increases in sexual risk behaviours as HIV treatment alters popular perceptions of the disease.

14. Considerable gains have been made in scaling up voluntary medical male circumcision, which has the potential to avert more than 20 per cent of all new infections projected through 2030. As at December 2012, 3.2 million African men aged 15 to 49 had been circumcised in the 14 sub-Saharan African countries where scale-up had been recommended. Although that represents only 15 per cent of the target of 20 million circumcisions by 2015, the pace of scale-up is rapidly accelerating, with more than double the number of circumcisions performed in 2012 than were performed in 2011. South Africa performed more male circumcisions than any other priority country, followed by Kenya, Mozambique, Rwanda, Uganda, the United Republic of Tanzania and Zambia, with each country performing more than 130,000 circumcision procedures in 2012. Kenya has achieved the highest circumcision coverage, having reached more than 60 per cent of its target as at December 2012. In 2013, WHO prequalified the first non-surgical circumcision

device for adults, offering a potentially attractive alternative to traditional surgical circumcision.

15. Failure to reach key populations with evidence-informed and human rights-based prevention services represents a critical gap in current efforts to reduce sexual HIV transmission. Prevention coverage for these populations remains inadequate in large measure owing to insufficient financing for such efforts, as only 10 per cent of HIV prevention funding supports programmes for key populations. Currently, the limited HIV prevention efforts for these key populations are overwhelmingly financed by international donors, underscoring the need for substantially greater national leadership and commitment to ensure that those most in need receive essential HIV prevention support.

16. There is growing evidence that social protection, livelihood protection, financial incentives and economic empowerment programmes reduce the risk of HIV acquisition by alleviating economic vulnerability, which may encourage risky behaviours. Studies of various cash transfer schemes in Lesotho, Malawi and the United Republic of Tanzania have found that such programmes encourage safer sexual behaviours and reduce new HIV and sexually transmitted infections among young women. As the number of countries with cash transfer programmes has steadily increased in recent years, efforts are needed to leverage such initiatives to strengthen HIV prevention efforts. A recent four-country review found that many people living with HIV experience barriers in accessing social protection schemes owing to such factors as stigma, bureaucratic complexity and lack of awareness.

2. Halve the transmission of HIV among people who inject drugs by 2015

17. Little progress has been made towards the global goal of reducing new HIV infections among people who inject drugs, with this population accounting for more than 40 per cent of new infections in some countries. Globally, people who inject drugs represent an estimated 0.2 to 0.5 per cent of the world's population (an estimated 14 million people) but make up 5 to 10 per cent of people living with HIV. Transmission through sharing contaminated injecting equipment is the driving force of national epidemics in Eastern Europe and Central Asia and in parts of East and South-East Asia and has emerged as an important factor in East Africa.

18. Although a comprehensive package of harm reduction services has been demonstrated to substantially lower the risk of HIV acquisition among people who inject drugs, service coverage remains extremely low. Globally, only 8 per cent of people who inject drugs have access to opioid substitution therapy and worldwide, only two clean needles are distributed per person per month. Punitive laws, including overuse of incarceration for people who inject drugs, and an acute lack of HIV services in prison settings impede efforts to address the HIV-related needs of people who inject drugs.

19. While global trends are discouraging, occasional hopeful signs have emerged, providing momentum on which to build a more robust, effective response for people who use drugs. According to recent surveys, more people who inject drugs report having used sterile equipment the last time they injected than in previous years. In addition, a number of countries have made funding for harm reduction services a priority: a practice that merits emulation by other countries.

3. Eliminate HIV infections among children and reduce maternal deaths

20. Progress continues in world efforts to prevent children from acquiring HIV. Since 2005, services to prevent mother-to-child transmission have averted 850,000 new infections among children. In 2012, some 260,000 (130,000 to 320,000) children were newly infected with HIV, a 52 per cent decline compared with 2001 and a 35 per cent reduction over the past three years. While these gains are historic, the pace of progress will need to increase if the world is to meet its goal of eliminating new HIV infections among children by 2015.

21. Although coverage of antiretroviral prophylaxis for pregnant women living with HIV continues to increase globally, rising from 57 per cent in 2011 to 62 per cent in 2012, coverage continues to lag in many countries. Prevention coverage for pregnant women remains below 50 per cent in 13 countries with generalized epidemics, below 30 per cent regionally in Asia and the Pacific, and below 20 per cent in the Middle East and North Africa.

22. The 2013 WHO guidelines, which call for lifelong antiretroviral therapy for pregnant women living with HIV, offer an important platform on which to accelerate progress towards the global goal of eliminating mother-to-child transmission and improving health outcomes for pregnant women and mothers living with HIV, as this approach has proved highly effective in spurring accelerated scale-up of prevention services in antenatal settings. Improving service coverage and outcomes will also demand more systematic collection, analysis and use of strategic information across the service cascade for prevention of mother-to-child transmission.

23. Other elements of effective prevention of new infections in children, as outlined in the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive: 2011-2015, have yet to be brought to scale. Antiretroviral coverage for pregnant women living with HIV is substantially lower during the breastfeeding period (49 per cent) than during pregnancy and delivery (62 per cent). While the unmet need for contraception declined somewhat between 1990 and 2010, gaps remain considerable, with more than 20 per cent of women in East and West Africa lacking access to family planning services. Modelling indicates that reducing the unmet need for family planning services is critical to reaching the 2015 target to eliminate mother-to-child transmission. In working to close gaps in the prevention continuum, countries should link programmes for pregnant women and children with broader efforts to reduce gender inequalities and provide women and girls with the tools they need to protect themselves from HIV.

24. The world is failing to address the needs of children living with HIV. Treatment-eligible children are about half as likely to obtain antiretroviral therapy as treatment-eligible adults. The 2013 WHO guidelines recommend initiation of antiretroviral therapy, regardless of CD4 count, for all children under age 5 who are living with HIV. Implementation of this approach will require substantial improvements in access to early infant diagnostic services, with three priority countries reporting diagnostic coverage of less than 5 per cent. In addition, urgent global attention is required to address the perceived lack of financial incentives for the development of a comprehensive array of paediatric antiretroviral formulations.

4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

25. As at December 2012, 9.7 million people in low- and middle-income countries were receiving antiretroviral therapy, an increase of 1.6 million over 2011. The steady expansion of access to antiretroviral therapy is transforming HIV responses across the world. From 1995 to 2012, antiretroviral therapy averted an estimated 6.6 million AIDS-related deaths worldwide, including 5.5 million in low- and middle-income countries. In KwaZulu-Natal, South Africa, scale-up of antiretroviral therapy has been associated with an increase of 11.3 years in life expectancy. According to a recent analysis by leading economists, earlier initiation of antiretroviral therapy is highly cost-effective, with manageable incremental costs associated with substantial increases in disability-adjusted life years averted.

26. While the scale-up of antiretroviral therapy represents one of the signal achievements in the history of global health, persistent gaps undermine efforts to achieve universal treatment access. In addition to the previously described treatment disparities among children, treatment-eligible men are 22 per cent less likely to receive HIV treatment compared with treatment-eligible women. Stigma and discrimination, often reinforced by punitive laws and policies, also deter utilization of HIV testing and treatment services by key populations. For example, it is estimated that only 4 per cent of treatment-eligible people who inject drugs are receiving antiretroviral therapy. Regionally, access to HIV treatment remains extremely low in Eastern Europe, Central Asia, the Middle East and North Africa. Treatment coverage is notably lower in West and Central Africa than in Eastern and Southern Africa.

27. Under the 2013 WHO guidelines, an estimated 28.6 million people worldwide are now eligible for antiretroviral therapy. It is clear that, at some point in their lives, all people living with HIV will require HIV treatment. Modelling by the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicates that achieving 95 per cent coverage under the 2013 guidelines would result in an 83 per cent decline in AIDS-related deaths by 2020 compared with the peak in HIV-related mortality in 2004. To implement the 2013 guidelines, service providers will need to be prepared to offer care that meets the needs of people at a much earlier stage of infection.

28. Countries urgently need to assess their national treatment guidelines, with the aim of aligning them with the 2013 WHO guidelines. A UNAIDS review of treatment guidelines in 108 countries in early 2014 found that only eight countries (including four in sub-Saharan Africa) had formally endorsed use of the 500 CD4 count threshold for treatment initiation for most people living with HIV. More than half of the countries (58) recommend initiation of treatment at 350 CD4 or less. By contrast, at least five countries, as well as the Canadian province of British Columbia, now recommend initiation of HIV treatment for all people diagnosed with HIV, regardless of CD4 count. In December 2013, Brazil became the first middle-income country to recommend offering HIV treatment for all, regardless of CD4 count, with priority to symptomatic individuals or asymptomatic individuals with CD4 counts below 500.

29. The comprehensiveness and effectiveness of service systems will also need to be improved in order to optimize the potential benefits of antiretroviral treatment. Owing to gaps across the treatment cascade, fewer than one in four people living with HIV in sub-Saharan Africa have achieved viral suppression, the clinical goal of

antiretroviral therapy. The typical person who enters HIV treatment in the region has a low CD4 count, and substantial percentages encounter difficulties in adhering to treatment or remaining in care. Food assistance, stigma reduction, patient navigation, peer-based adherence support, innovative use of mobile communications technologies and other strategies have proved effective in reducing patient loss across the treatment cascade.

30. As antiretroviral therapy is lifelong, planning for sustainability needs to be built into national treatment programmes. Expanding employment opportunities for people living with HIV has an important role to play in sustaining treatment gains, since people living with HIV who are employed are 39 per cent more likely to adhere to prescribed regimens as those who are unemployed. In the light of the increase in 2013 in humanitarian emergencies resulting from conflict and natural disaster, plans should be in place to ensure continuity of HIV treatment when and where such emergencies arise.

31. Further lowering the costs of antiretroviral medicines remains a critical priority. Countries such as South Africa and Swaziland have achieved notable reductions in the prices of antiretroviral medicines through careful structuring of national tenders. Steps to preserve a robust manufacturing capacity for generic medicines are critically important. In addition, countries urgently need to maximize the use of flexibilities available under international rules for intellectual property and avoid making commitments that might impede their ability to use trade-related intellectual property rights (TRIPS) flexibilities to the fullest extent possible. This becomes all the more important as multilateral funding for HIV treatment becomes less available in regions with many middle-income countries, such as Eastern Europe, Central Asia, Latin America and the Caribbean.

32. In 2013, UNAIDS joined with WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief to launch the Treatment 2015 initiative, which provides a road map for accelerating treatment scale-up, including in the years beyond 2015. This new initiative urges focused attention on neglected aspects of the treatment agenda, including the urgent need to invest in strategies to increase demand for testing and treatment services. Treatment 2015 calls for all countries to establish new treatment targets to reflect the 2013 WHO guidelines and to routinely monitor outcomes across the treatment cascade. Partners in the initiative have joined together to intensify financial and technical support to 30 priority countries that account for 90 per cent of the unmet need for HIV treatment.

5. Halve tuberculosis deaths among people living with HIV by 2015

33. Tuberculosis remains the leading cause of death among people living with HIV, although the goal of halving tuberculosis deaths among people living with HIV by 2015 appears to be within reach. Since 2004, the annual number of tuberculosis-related deaths among people living with HIV has declined by 36 per cent, with reductions of more than 50 per cent in 17 of 41 countries with a high HIV/tuberculosis burden. WHO estimates that the scale-up of collaborative HIV/tuberculosis activities prevented 1.3 million people from dying between 2005 and 2012. As in other aspects of the response, progress in reducing tuberculosis-related deaths among people living with HIV varies substantially, with 15 high-burden countries reporting a drop in such deaths of less than 25 per cent.

34. Antiretroviral therapy reduces by 65 per cent the risk that a person living with HIV will develop tuberculosis. However, HIV treatment coverage is lower among individuals co-infected with HIV and tuberculosis than among other people living with HIV. Among 41 priority countries, only 4 (Brazil, Kenya, Malawi and Ukraine) provided HIV treatment to at least 50 per cent of incident HIV and tuberculosis cases. Diagnosis of co-infection remains a major impediment to further progress, with only 46 per cent of notified tuberculosis cases tested for HIV in 2012. The cost of treatment, particularly for extensively drug-resistant tuberculosis, is increasingly posing a barrier in some countries, underscoring the need for countries to maximize the use of TRIPS flexibilities to ensure access to affordable treatments.

6. Close the AIDS resource gap

35. Total resources available for HIV-related activities rose in 2012, reaching an estimated $18.9 billion, which represents a 10 per cent increase over amounts mobilized in 2011. However, the world is not on track to generate at least $22 billion to $24 billion in resources by 2015. It is estimated that the implementation of the 2013 WHO guidelines will require an additional 5 to 10 per cent in resources, over and above resource needs previously projected for 2015 and beyond.

36. As in other aspects of the response, the mobilization of sufficient financial resources needs to reflect a shared responsibility for efforts to address the epidemic. In 2012, for the second year in a row, domestic sources accounted for a majority of HIV funding, contributing 53 per cent of expenditure. Among 43 low- and middle-income countries that reported spending data in 2012, more than two thirds reported an increase in domestic resources, with Chad, Guinea, Kyrgyzstan and Sierra Leone more than doubling domestic spending.

37. Many countries, especially those with limited capacity to increase domestic spending, will remain dependent on international actors to help to finance the response. In 2012, international HIV assistance rose by 8 per cent, returning international assistance to the funding peak achieved in 2009. Most of international HIV assistance (67 per cent) flowed through bilateral channels in 2012, with multilateral platforms accounting for 28 per cent of international spending. Through the United States President's Emergency Plan for AIDS Relief, the United States remains the largest provider of HIV assistance. In December 2013, international donors pledged $12 billion to the Global Fund over three years, a 30 per cent increase over the previous three-year replenishment.

38. At the same time that countries pursue every means available to mobilize needed resources, efforts should be redoubled to ensure that available funding is invested smartly. With assistance from international partners, at least 30 countries have either developed, or made plans to develop, HIV investment cases. Development of an investment case enables countries to improve the strategic targeting of programmes, adapt service approaches to improve efficiency and explore innovative strategies for mobilizing new resources. Nigeria, for example, is taking steps to improve the strategic focus of programmes after determining that 12 states and the Federal Capital Territory account for 70 per cent of all new HIV infections, while Myanmar has embarked on a national effort to scale up programming for key populations. Several countries are studying various options to mobilize sustainable financing, such as national HIV trust funds, mandatory

earmarks in ministry budgets and new tax levies on telecommunications and airline tickets. Anticipating diminished access to international assistance, some middle-income countries, including Belarus, Jamaica, Thailand and Ukraine, have committed to assume future costs associated with a scaled-up response. By investing $1.1 billion in a refocused response, Kenya projects that it will prevent 1.15 million new HIV infections and 760,000 AIDS-related deaths and offset more than half of such investments through savings in treatment costs and improvements in labour productivity.

39. To finance the long-term effort that will be required, principles of global solidarity and shared responsibility will need to drive the response. While maintaining robust international commitment, new sources of financing that extend beyond official development assistance channels will be needed. Many countries are already advancing towards this aim, but international mechanisms to support innovation at the regional and country levels will be required to maximize the flexibility of national decision-makers to implement new, self-sustaining financing options.

7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

40. The epidemic's disproportionate impact on women and girls manifests itself in many ways. In settings with high HIV prevalence, young women aged 15 to 24 experience tuberculosis rates 1.5 to 2 times higher than men in the same age group. Women living with HIV confront a heightened risk of cervical cancer, barriers to accessing essential health-care and support services and impediments to access to justice. Unequal gender norms diminish women's ability to negotiate condom use while also disadvantaging men, who engage in higher levels of risk behaviour than women. In many cases, a discriminatory legal and policy environment further exacerbates women's already substantial vulnerability and risk.

41. Gender-based violence is both a cause and consequence of HIV infection. According to data from nearly 50 countries, between 9 and 60 per cent of women aged 15 to 59 report having experienced violence at the hands of an intimate partner in the past 12 months. Two recent studies in Uganda and South Africa found that women who had experienced intimate partner violence were 50 per cent more likely to be living with HIV than women who had not experienced violence. Studies have linked sexual abuse during childhood with increased risk-taking later in life. Among women living with HIV, disclosure of their HIV status may also subject them to the risk of gender-based violence. Intensified national action to protect women and girls from sexual and other forms of gender-based violence is an urgent necessity.

42. Consistent with the emphasis on women's health and rights in the Five-Year Action Agenda of the Secretary-General and the commitments set forth in the 2011 Political Declaration, national HIV responses must be grounded in a commitment to gender equality. Fewer than half of countries have scaled up national funding for male engagement to promote gender equality or for national-level integration of sexual and reproductive health-care and HIV services or have provisions in the national strategic plan to allocate funding for women's community organizations.

8. Eliminate HIV-related stigma, discrimination, punitive laws and practices

43. Stigma and discrimination continue to undermine effective AIDS responses. Surveys conducted in 35 countries through the People Living with HIV Stigma Index indicate that discriminatory behaviour towards people living with HIV remains common. In eight countries, at least one in five people living with HIV reported having been denied health or dental care, with at least one in six people in five countries having been refused employment.

44. In the 2011 Political Declaration on HIV and AIDS, Member States reiterated their commitment to "strengthen national policies and legislation to address [HIV-related] stigma and discrimination". In 2012, 61 per cent of countries reported the existence of anti-discrimination laws that protect people living with HIV. However, in 17 out of 23 countries where surveys were conducted between 2008 and 2013, less than 30 per cent of people who had experienced HIV-related discrimination reported having sought legal redress. The share of countries with HIV-related legal services rose from 45 per cent in 2008 to 55 per cent in 2012 — important progress but well shy of ensuring that all people living with HIV are able to defend their rights.

45. Similarly, punitive laws and practices undermine efforts to bring HIV treatment to all who need it. As at 2013, 63 countries had HIV-specific provisions that allowed for the prosecution of HIV non-disclosure, exposure and/or transmission. The provisions of those laws are often contrary to sound medical evidence and can create a climate of fear and blame that discourages the uptake of HIV testing and treatment. In recent years, several countries, including Congo, Guinea, Guyana, Fiji, Senegal, Togo and Switzerland, have either repealed or rejected such laws or taken steps to restrict their breadth solely to cases of intentional transmission.

46. Effective action to address the HIV-related needs of key populations continues to be undermined by punitive legal frameworks. Sixty per cent of national Governments and non-governmental survey respondents in 70 per cent of countries report the existence of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups. Most countries have laws that criminalize some aspect of sex work and a number of countries are reportedly considering laws that criminalize the purchase of consensual sex between adults. People who use drugs are commonly exposed to punitive legal approaches, including through compulsory drug detention centres where living conditions are considered inhumane and degrading by the Special Rapporteur on torture or other cruel, inhuman or degrading treatment or punishment.

47. Even as a growing number of countries are moving towards greater recognition of the human rights of lesbian, gay, bisexual and transgender people, new punitive laws have emerged in some regions, further criminalizing such populations and/or limiting their freedom of association and expression. Such laws are incompatible with human rights standards and with an effective HIV response, since people who are criminalized are unlikely to seek essential prevention and treatment services. Moreover, as recent experience shows, such laws also invite potential violence and discrimination against members of those communities.

48. In line with commitments made in the 2011 Political Declaration, countries should immediately take steps to review their legal and policy frameworks in order to bring them into line with human rights obligations. Countries should ensure that those living with HIV and most vulnerable to it are free of criminal sanctions and are able to access the information and tools required to protect themselves and others from infection. People living with HIV and members of key populations and vulnerable groups should have meaningful access to legal services and benefit from programmes to address discrimination.

9. Eliminate HIV-related restrictions on entry, stay and residence

49. There is a decisive movement away from discriminatory restrictions on the entry, stay and residence of people living with HIV. Since 2010, 12 countries, territories or areas have eliminated such restrictions. Most recently, in 2013, Mongolia and Uzbekistan removed their respective restrictions on entry, stay and residence and Andorra and Slovakia reported that restrictions were no longer in force. In 2014, Tajikistan also removed its HIV-related restrictions on entry, stay and residence.

50. However, 40 countries, territories and areas continue to have such restrictions in place, highlighting the need for further action to ensure worldwide elimination of these laws, regulations and policies, including in countries that are important destinations for millions of migrant workers.

51. In addition to reflecting and reinforcing stigmatizing attitudes towards people living with HIV, restrictive laws also inflict considerable harm on individuals and households and undermine an effective, evidence-based response to HIV. Migrants exposed to such laws are frequently tested for HIV without their knowledge or consent, provided little if any counselling and given no access to follow-up medical care if HIV-positive. Such HIV-related restrictions also undermine businesses, which depend on the ability to recruit and deploy employees as needed in order to succeed in a globalized, highly competitive world.

10. Strengthen HIV integration

52. Sustaining the HIV response demands a closer integration of HIV into other health and development efforts. Within the health sector, HIV services need to be linked with other services, while steps are needed to ensure that non-health sectors are HIV-sensitive. More than 90 per cent of countries indicate that integration of HIV into other systems is a national priority. Effective integration requires action with respect to joint planning, policy guidance, programme implementation, service delivery and monitoring and evaluation.

53. Forty-five per cent of countries that undertook midterm reviews of progress towards the 2015 targets indicate that HIV has been aligned with planning for other diseases or integrated into national health and development plans. Countries have taken various routes, including linking HIV with broader health planning or integrating HIV services into national health insurance schemes.

54. At the level of service provision, HIV integration is increasingly common. Fifty-three per cent of countries have taken active steps towards fully integrating HIV/tuberculosis services or strengthening joint service provision. Seventy per cent of countries report having integrated HIV testing, counselling and services into

antenatal care and maternal and child health-care services. Two thirds of countries have integrated HIV into sexual and reproductive health-care services, 23 per cent report having linked HIV services with services for chronic non-communicable diseases, and 55 per cent have integrated HIV testing and counselling into general outpatient care.

55. Although important gains have been made in taking HIV out of isolation, countries are at different stages with respect to integrating HIV into the broader health sector and other development sectors. Given the broad diversity of national epidemics, circumstances and needs, what works in one country with respect to integration of planning and services will not necessarily work in others. International donors need to ensure that their approaches do not inhibit effective integration and alignment, while countries should work to adapt and strengthen governance structures to support integration. Moving forward, particular emphasis is needed to increase HIV-sensitive social protection schemes. Further action is also needed to ensure that integrated services are acceptable and accessible to key populations, including steps to address stigmatizing or judgmental attitudes among some health-care providers.

IV. Using the AIDS response to catalyse health, equity and human rights

56. Progress over the past decade, combined with important advances in scientific research, has increased confidence in the feasibility of eventually ending the AIDS epidemic. However, realizing this will depend on follow-through after the expiration of the 2015 targets. The history of global health and development is replete with examples of disease-specific efforts that generated substantial progress only to falter at the last mile. Having witnessed historic reductions in new HIV infections and AIDS-related deaths, the global community now has the moral imperative to seize this opportunity for ending AIDS.

57. As the deadline for the 2015 targets approaches, work has intensified to conceptualize a global development agenda beyond 2015. The post-2015 framework must ensure the continuation, strengthening and sharpening of the Millennium Development Goals.

Learning from the AIDS response for sustainable development

58. Much of what has been learned from the AIDS response can help to strengthen broader development efforts. The response's emphasis on accountability, reflected through a series of time-bound targets endorsed by countries and regular reporting on results, has influenced the broader development field, which has taken on board the importance of target-setting, measurement, disaggregation, transparency and the participation of affected communities in the response. The reliance on evidence and data, including information supplied by communities themselves, has enhanced the strategic focus of the HIV response, contributed to rapid problem-solving and helped advocates to make the case for political and financial investments in HIV programmes.

59. More than any other global health movement, the AIDS response has been grounded in advocacy by individuals directly affected by the health condition.

Activism has given voice to people, including those who are poor and marginalized, and forced those with power to take notice and to respond. This activism has also helped to create extensive networks of people living with HIV, who provide mutual support, combat stigma and discrimination, and deliver essential services. HIV provides useful lessons for how people-centred approaches can strengthen a broad array of global health and development initiatives.

60. The AIDS response has demonstrated both the feasibility and the extraordinary benefits of addressing a chronic health condition in an evidence-driven, coordinated manner. HIV has galvanized a rethinking of health systems, integrating community workers into health programmes and generating innovative models of service delivery. These lessons have value for other health and development challenges for which existing systems, as they have previously evolved, have proved inadequate to the challenges of a rapidly changing world.

61. The AIDS response vividly illustrates the vital role of innovation in solving difficult problems and addressing complex challenges. After the slow scale-up of services to prevent mother-to-child HIV transmission in the aftermath of definitive research findings, health systems and local programmes began to innovate, identifying models and approaches to overcome bottlenecks and expedite service expansion, including attention to scale-up of antiretroviral treatment for women. The AIDS response has increased the momentum towards new ways of thinking about intellectual property rules and catalysed an array of innovative funding mechanisms, including the Global Fund and the International Drug Purchase Facility, UNITAID.

62. The AIDS response has helped the broader development field to recognize the critical importance of affected populations and communities as partners and change agents. Indeed, HIV funding has supported the development of robust civil society institutions in communities throughout the world, as well as such institutional partnership models as the country coordinating mechanisms of the Global Fund. HIV has attracted the extensive engagement of diverse non-State actors, including faith-based communities and private businesses.

63. Experience with HIV has also emphatically underscored the essential importance of grounding health and development efforts in human rights principles. Perhaps more than any other issue of our time, HIV has highlighted the pernicious health effects of gender inequalities and social and legal marginalization. The insistence on an approach that leaves no one behind is a powerful demonstration of advancing progress towards multiple health and development aims.

64. HIV has also demonstrated the critical importance of strong political leadership and commitment to tackle complex, multidimensional challenges. In particular, HIV vividly illustrates what can be achieved through sustained international solidarity and shared responsibility.

Positioning AIDS in the post-2015 world

65. One of the many virtues of the Millennium Development Goals was their recognition of the central role of health in efforts to improve human well-being. According to a panel of experts convened by *The Lancet* to examine the place of HIV and other health issues in the post-2015 development agenda, improvements in life expectancy account for 24 per cent of the growth in income in low- and middle-

income countries from 2000 to 2011. These computations strikingly illuminate what the HIV field has long understood, namely, that societies cannot optimally grow, prosper and become more just without a foundation of good health and well-being that is widely shared.

66. By extension, HIV has highlighted the degree to which health status is powerfully affected by poverty, economic and social inequalities, discrimination and marginalization. In its adoption in 2013 of a resolution recognizing UNAIDS as a model for strategic coherence, coordination, results-based focus and country-level impact (resolution 2013/11), the Economic and Social Council emphasized the importance of ensuring that responding to AIDS remains a priority in the post-2015 development agenda.

67. To effectively position the HIV response and other health and development actors to achieve its aims in the post-2015 world, steps are needed to strengthen the health and development architecture. The HIV response should leverage and accelerate the growing push to achieve universal access to high-quality, accessible and affordable health care. Links between health initiatives and broader development efforts need to be reflected more fully across the breadth of global health and development practice. Focused efforts should:

- Bring essential health care and social services closer to the communities that need them through accelerated decentralization and greater attention to equity issues
- Ground health and development efforts in a codified, human rights-based approach
- Promote service integration and institutional streamlining
- Ensure data systems that provide ongoing, disaggregated, relevant and timely feedback and strategic information
- Strengthen national budgetary and health systems, with a particular emphasis on preparing them to look beyond short-term goals to achieve durable, longer-lasting improvements in health status
- Support and leverage non-State actors, including those most affected, to engage more fully and effectively in the response.

68. While continued efforts will be needed to integrate the HIV response into the broader health and development architecture, the post-2015 development agenda must recognize both the singular challenge that AIDS poses and the fact that the vision of ending AIDS is achievable. The post-2015 agenda needs to prioritize the target of ending AIDS, not only to avert profound human suffering but also as a catalyst towards a fairer, healthier and more just world.

V. Recommendations

69. Emerging opportunities, persistent challenges and the approaching deadline for the Millennium Development Goals and the 2011 Political Declaration on HIV and AIDS require joint action by countries, civil society, international donors, the United Nations system and other key partners to implement the following recommendations:

- **Expedite progress towards the 2015 targets and elimination commitments**. With the deadline fast approaching, concerted efforts are needed to expedite progress towards the targets to which the global community has committed. In particular, services should focus on geographic settings and populations where HIV prevalence and incidence are highest and where unmet need for critical services is most acute. Countries should actively encourage and incentivize innovation and undertake intensive efforts to strengthen health and community systems.

- **Close gaps in access to services**. Priority attention is required to ensure that all individuals, populations and communities have equitable and non-discriminatory access to HIV services. Countries should monitor service coverage for key populations, including developing size estimates and monitoring and evaluation metrics, and use the data generated from those systems to close access gaps. To prevent AIDS-related deaths among adolescents, critical focus is needed to ensure the availability and effective promotion of service options that welcome young people. Partners in the response must immediately take steps to increase capacity for early infant diagnosis, the testing of older children and linkage to the delivery of child-appropriate treatment and care. Countries must prioritize steps to prevent gender-based violence and remove other legal, social and economic factors that increase the vulnerability of women and girls and diminish their meaningful access to lifesaving prevention, treatment and care services.

- **Replace punitive approaches with protective ones**. Countries should take immediate steps to end punitive laws and law enforcement that act as barriers to health and HIV services and replace them with protective laws against discrimination, violence, hate crimes and mandatory testing and treatment. This reflects the overwhelming evidence that punitive approaches have no public health basis, violate fundamental human rights and undermine efforts to respond effectively to HIV. An effective HIV response is one of inclusion and participation, strong community support, the free dissemination of knowledge and awareness, and outreach to and protection of the most marginalized.

- **Develop new, ambitious targets to end the AIDS epidemic**. The HIV response needs to develop new targets to drive progress, unite diverse stakeholders and promote accountability and transparency. Recognizing dramatic changes in the evidence base for HIV treatment since the 2011 Political Declaration, as reflected in the 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*, UNAIDS has joined with diverse partners and stakeholders to launch a process to develop new HIV targets for 2020 and 2030. Key indicators to measure progress beyond 2015 should include HIV incidence, coverage of antiretroviral therapy, the elimination of stigma and other metrics of social determinants for the spread of HIV. Countries are encouraged not only to develop new, numerical targets for scale-up, but also to develop specific targets for populations that are not benefiting equally from scientific and programmatic advances. In addition, specific targets and monitoring mechanisms are needed to assess issues of quality, including effective linkage to, and retention in, key services. I recommend that the General Assembly consider a high-level meeting in 2016, in line with the UNAIDS Programme Coordinating Board recommendation of December 2013, to reaffirm and renew political

commitments and to ensure accountability towards the achievement of universal access to HIV prevention, treatment, care and support in the post-2015 era.

- **Create national investment cases**. Countries and international stakeholders should prioritize planning for the sustainability of national responses. All countries are encouraged to increase the impact of HIV investments and ensure robust value for money. Many are not investing domestic resources consistent with their national wealth and epidemic burden. Specific attention is therefore needed to develop strategies and mechanisms that generate new domestic resources for the long term. National investment cases can utilize innovative resource mobilization mechanisms such as new tax levies, national trust funds and mandatory budget earmarks. Countries can use their HIV investment case to identify improved delivery mechanisms, savings on procurement and other strategies to lower costs. While countries increase their domestic resources for HIV, international solidarity will remain vital. Countries with limited fiscal space will continue to need access to international HIV and health assistance. In particular, long-term financing continues to depend on the strength, robustness and flexibility of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- **Integrate the HIV response**. Ending AIDS should be a development priority in the post-2015 agenda and the lessons that the AIDS response brings to solving other complex development issues in future years should be recognized and acted upon. Ending AIDS will help to catalyse broad-based efforts to deliver a global social justice agenda beyond 2015 and will be an example of an approach where no one is left behind and where all people are united in a common commitment to human rights, gender equality, inclusive governance and social inclusion. Efforts should therefore be made to integrate HIV into broader health and development efforts, to strengthen health and community systems and to dismantle duplicative or parallel systems for planning and programme implementation. Young people and affected communities must be empowered to drive this change.